Pain Management Center
NY Spine Medicine

Operative Report

Date of Operation: 2-27-13
Patient's Name: Paul Aiken
Surgeon: Doug Schottenstein, MD
Preoperative Diagnosis: Lumbar Radiculitis
Postoperative Diagnosis: Same
Anesthesia: Local
Anesthesiologist: N/A

Proeedure: L2-3 Epidural Steroid Injection

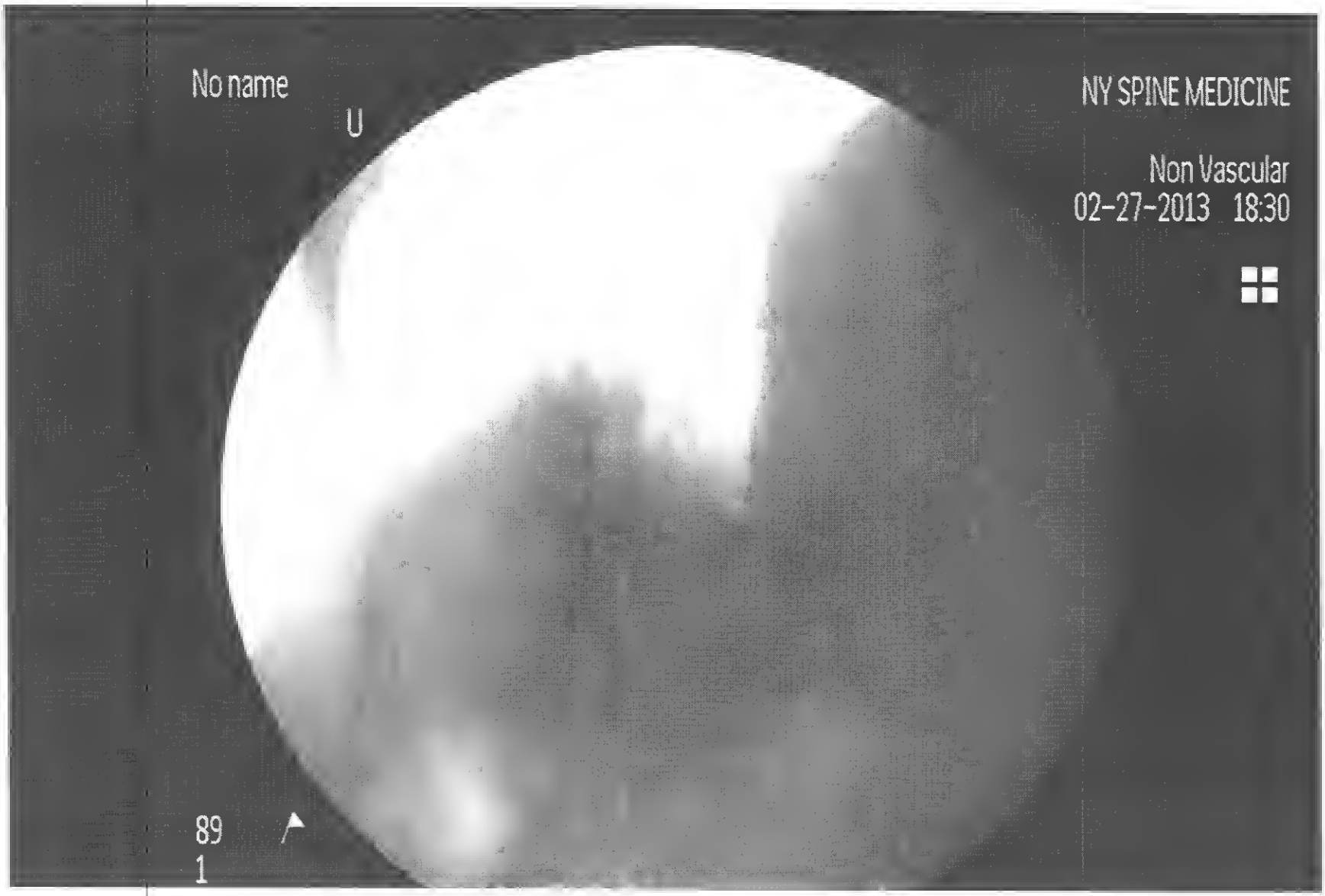
Assessment:
The patient presents today with the same complaints as previously noted. The condition remains unchanged, and all questions have been answered. Informed consent was obtained.

Teehnique:
The lumbar epidural was done in a prone position with a pillow placed under the abdomen to reduce lumbar lordosis. The patient was prepped and draped in a sterile fashion. The L2-3 interspace was identified using PA Fluoroscopy. A 20-gauge Touhy needle was inserted through a 1% lidocaine skin wheal into the L2-3 interspace utilizing fluoroscopy and the loss of resistance technique. The epidural space was confirmed with PA and lateral fluoroscopic views. There was no cerebrospinal fluid or blood on aspiration.

0.5cc Omnipaque 240 was then injected, with good spread of contrast in the epidural space, above and below the injection site.

At this point, Kenalog 80 mg diluted to 6cc in normal saline was then injected into the epidural space. The patient tolerated the procedure well without complications, and was discharged to home in good condition. Instructions were given to the patient. Follow up will be arranged by the patient.

Doug Schottenstein, MD
Pain Management Specialist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Date of Service: 02-27-2013
Name: AIKEN, PAUL
Age: 54 years DOB: 01/31/1959
Chart #: CI60381

CHIEF COMPLAINT/HPI:
Mr. AIKEN is a 54 years gentleman in no acute distress, who presents today with pain in the lower back.
Patient recalls low back pain for 30 years ago for no apparent reason. He saw several MDs and received MRI, CT myelogram, EMG, XR, PT, chiro, NSAIDs, and surgery with minimal relief. Patient next referred to pain mgmt by Dr. McCance. His complaint is located in the lower back. It is achy and dull in nature. The pain radiates to his right buttock. On a scale of 10, he rates the symptom as 2. This has been ongoing for 30 years. It occurs intermittently. It is better with lying down and rest. There are no associated signs/symptoms. The patient has received NSAIDs, physical therapy and surgery in the past for this problem. It worsens with prolonged sitting.

PAST MEDICAL HISTORY:
Past medical history is significant for asthma.

PAST SURGICAL HISTORY:
Past surgical history is significant for lumbar fusion, lumbar fusion repair surgery, tonsillectomy, and left knee surgery.

FAMILY MEDICAL HISTORY:
The patient reports his family history to be non-contributory.

SOCIAL HISTORY:
He denies smoking. He admits to drinking occasionally.

Medication historyVyvanse 40 mg capsule.
ALLERGIES: No Known Allergies

PHYSICAL EXAMINATION

LOWER EXTREMITY NEURO EXAM: There is 5/5 motor strength, no sensory deficits, and reflexes are +2/4 throughout. Straight leg raise is positive on the right and positive on the left.
THOROCOLUMBAR: Palpation of the bilateral paravertebral muscles reveal spasm and trigger

points. Palpation of the lumbar facet joints bilaterally at L 3, 4 and 5 replicates familiar pain. NEUROLOGICAL: Exam reveals gait and station to be normal. Negative Rhomberg. Cranial nerves II-XII are WNL. Sensory examination normal to vibration, pinprick, proprioception. Cerebellar examination is normal finger-to-nose and heel-to-shin. There is no ataxia or tremor. DTR's are +2 and symmetric.

DATA REVIEWED: CT myelogram scan of the lumbar spine: reveals moderate L3-4 disc and facet degeneration and severe stenosis . EMG: reveals left central conduction defect. MRI of the lumbar spine: reveals scoliosis, DDD, stenosis, and grade 2 anterolisthesis at L5-S1. X-ray of the lumbar spine: reveals degenerative changes.

ASSESSMENT/PLAN

DIAGNOSIS:
Lumbosacral Radiculitis (724.4)
Post Laminectomy Syndrome Lumbar (722.83)

INTERVENTIONS/RECOMMENDATIONS:
I recommended lumbar epidural steroid injection to this patient. The risks vs. benefits of the procedure were discussed. The patient has agreed. I ordered a PFS of the LE. He was advised to continue his current medications. An appropriate exercise plan was discussed. The patient is scheduled for follow-up in my office in 2 weeks.

Douglas C. Schottenstein, MD

Board Certified Neurology

Board Certified Pain Management